Testimony Regarding Proposed Senate Bill 1
An Act Increasing Access to Affordable, Quality Health Care
Lisa Reynolds, Planner
Wednesday, January 31, 2007

Members of the Public Health Committee, thank you for this opportunity to support increased access to affordable, quality health care for every Connecticut resident.

I am Lisa Reynolds, Planner for Senior Resources, the Eastern Connecticut Area Agency on Aging. I am also the co-chair of the Health Care for All Coalition and a member of the Board of Directors for the Connecticut Coalition on Aging, Inc. I am also the mother of an adult child without health insurance, and can assure you that Connecticut's health care crisis affects each of us.

Undoubtedly the members of the committee are well aware of the state's health care statistics. It's estimated that 1 of every 10 residents is without health insurance, and that more than 80% of these families have at least one working adult. The things we look forward to, like graduating college, can leave us uninsured. The things we dread, like divorce, a major accident, serious illness or job loss can leave us uninsured. Employers are struggling with employee health care, and many businesses simply cannot afford to provide it. Health insurance costs are rising faster than wages. Hospitals are crushed by the cost of caring for the uninsured. Older adults are not immune to the lack of health insurance. Medicare, the national health insurance program, is <u>not</u> a welfare program. While most people aged 65 and older are eligible, there is a population of persons who do not qualify and their needs should also be taken into account. Voluntary enrollees in Medicare can have monthly premiums totaling $503.50, well over $6,000 a year. As you explore possible solutions, I encourage you to adopt the principles outlined by the Institute of Medicine to ensure that any strategy you select is

- **Universal**: no one is left out
- **Continuous** and **portable**: it stays with you regardless of marital status, employment or change of address
- **Affordable** to **individuals and families**: regardless of economic circumstances
- **Affordable** and **sustainable for society**: works for, not against, our economy
- **Better for our health and well-being**: produces access to high quality care for all

Thank you.

Senior Resources
AGENCY ON AGING
4 Broadway • 3rd Floor • Norwich, Connecticut • 06360
(860) 887-3561 • (800) 690-6998 • Fax (860) 886-4736 • www.seniorresourcesec.org

2007 MEDICARE DEDUCTIBLE, CO-INSURANCE, & PREMIUM AMOUNTS

PART A

Hospital

Deductible: $992

Co-Insurance:

1st through 60th day: $0

61st through 90th day: $248.00/day

91st through 150th day: $496.00/day

Skilled Nursing Facility

Co-Insurance:

1st through 20th day: $0

21st through 100th day: $124.00/day

Part A Premium (for voluntary enrollees only):

$410.00 /month (if individual has 29 or fewer quarters of Social Security coverage)

$226.00 /month (if individual has 30-39 quarters of Social Security coverage)

If uncertain of quarters, please call your local Social Security office.

PART B

Deductible: $131.00/year

Premium: $93.50/month

(Higher if individual income>$80,000)

Center for Medicare Advocacy, Inc.

www.medicareadvocacy.org

MEDICARE, MEDIGAP, MEDICAID AND RELATED PROGRAMS

Overview of the Medicare Program

Medicare is the national health insurance program to which all Social Security recipients who are either over 65 years of age or permanently disabled are entitled. In addition, individuals receiving Railroad Retirement benefits and individuals suffering from end stage renal disease are eligible to receive Medicare benefits.

Medicare is not a welfare program, and should not be confused with Medicaid. The income and assets of a Medicare beneficiary are not a consideration in determining eligibility or benefit payment. Medicare is a national program and procedures should generally not vary significantly from state to state.

Coverage under Medicare is similar to that provided by private insurance companies: it pays a portion of the cost of medical care. Often, deductibles and co-insurance (partial payment of initial and subsequent costs) are required of the beneficiary.

Medicare has three substantive coverage components, Parts A, B, and D. Part A covers inpatient hospital care, hospice care, inpatient care in a skilled nursing facility, and home health care services. Part B covers medical care and services provided by doctors and other medical practitioners, durable medical equipment, and some outpatient care and home health services. Part D is the new prescription drug program that is provided by a large number and variety of private plans.

Part A of the program is financed largely through federal payroll taxes paid into Social Security by employers and employees. Parts B and D are financed by monthly premiums paid by Medicare beneficiaries and by general revenues from the federal government. In addition, Medicare beneficiaries themselves share the cost of the program through copayments and deductibles that are required for many of the services covered under Parts A, B, and D.

In January 1, 1999 Congress introduced a set of financing options outside the traditional Medicare program under a new Medicare Part C (also known as Medicare+Choice). The Medicare Act of 2003 changed the name of the program to Medicare Advantage. Medicare Advantage financing options include "coordinated care plans," which include managed care plans, as well as health savings accounts, private fee-for-service plans, and other systems. In Connecticut and most areas of the country only managed care plans have developed as options, and many managed care plans have withdrawn from Medicare. The Centers for Medicare & Medicaid Services (CMS), the agency that administers the Medicare program, has given Medicare Advantage a great deal of financial support and has encouraged beneficiaries to join.

As a result of CMS's encouragement and financial support, a significant number of beneficiaries finance their Medicare health services through managed care plans. The Medicare managed care benefit is different from the traditional Medicare system but coverage should generally be the same or broader. Generally, a Medicare managed care plan administers the health care treatment of an enrollee by the use of a physician (known as a "gatekeeper") who must approve the patient's referral to specialized care. (Some Medicare managed care plans permit beneficiaries to go directly to a specialized care provider, without the gatekeeper's approval, in return for payment of an extra premium.) A beneficiary may choose to receive Medicare coverage and care through a managed care plan by filing an enrollment form. Once the choice is made, the beneficiary generally must receive all of his or her services, including medications, through the plan in order to receive Medicare coverage. Beneficiaries can change their minds, disenroll from their managed care plan, and return to "original" Medicare, but only during an annual election period which occurs from November 15th to December 31st.

Connecticut: Spending and Worrying More but Getting Less

In 2005, Connecticut spent a staggering $15 billion on health care, two-thirds of which was used for nonelderly residents,[1] but we are not getting our money's worth. Some 355,000 residents continue to lack any health care coverage, and that number is growing. Eighty percent of Connecticut residents without insurance are employed, and 75,000 are under age 18. Like the rest of the country, Connecticut relies largely on employer-based health insurance.

Health insurance premiums for a Connecticut family are the sixth highest in the nation; premiums for an employee plus a dependent rank second, and premiums for an individual rank twelfth.

Average daily hospital costs in Connecticut are sixth highest in the nation, exceeding the national average by 23 percent.

Those most likely to be uninsured earn too much to qualify for public programs but too little to pay for health coverage on their own. By the time the uninsured seek care, they are more often seriously ill, and more costly to treat. In 2005, $572 million was spent directly on health care for uninsured residents. The indirect toll of Connecticut's current level of uninsurance costs residents between $652 million and $1.3 billion a year, based on findings of the Institute of Medicine.

Today, Connecticut employers and their employees are spending an average of 13.3 percent of their payrolls on health insurance benefits. Facing unbridled health insurance expenses, employers, especially small businesses, are caught in a moral and economic bind, forcing many to choose between the health of their employees and their bottom lines. Businesses, families and communities in Connecticut all want the same thing: quality health care that is affordable, accessible and sustainable.

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Universal Health Care Foundation report